USAID BIRTHSPACING PROGRAMMATIC REVIEW

AN ASSESSMENT OF COUNTRY–LEVEL PROGRAMS, COMMUNICATIONS, AND TRAINING MATERIALS

EXECUTIVE SUMMARY

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February 2004

Submitted by:
LTG Associates, Inc.
Social & Scientific Systems, Inc.

Submitted to:
The United States Agency for International Development
Under USAID Contract No. HRN–C–00–00–00007–00

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USAID Birthspacing Programmatic Review was made possible through support provided by the United States Agency for International Development (USAID) under the terms of Contract Number HRN–C–00–00–00007–00, POPTECH Assignment Number 2003–154. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

ACKNOWLEDGMENTS

This assessment would not have been possible without the generous assistance and active participation of cooperating agencies that are actively working in family planning and reproductive health service delivery around the world. Data collection was greatly facilitated and improved by the efforts of these dedicated health professionals. The team would particularly like to acknowledge the help of the following projects and organizations for their active support and assistance: Advance Africa Project, CATALYST Consortium, Centre for Development and Population Activities (CEDPA), EngenderHealth, JHPIEGO, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP), PRIME II, and Pathfinder.

The team would also like to thank Dr. Kola Oyediran of CEDPA/Nigeria, Dr. S. Bodh of EngenderHealth/India, Ms. Sereen Thaddeus of USAID/Uganda, Dr. Maria Lorencikova of EngenderHealth/Bolivia, and Dr. Irma Ramos of CATALYST/Peru for their fantastic help in planning and arranging productive field visits for the indepth information gathering phase of the assessment. The team appreciates and extends its gratitude to all in Peru, Bolivia, Nigeria, Uganda, and India who helped make the country visits so productive and informative, in particular to all the EngenderHealth staff who provided support during the La Paz work, and to all the Bolivian professionals who shared their thoughts and experiences with birthspacing.

Deep appreciation is extended to Bruce Carlson and Melanie Kindsfather of POPTECH, who provided clear direction and invaluable support during the entire assessment. Special thanks are extended to Harris Solomon from USAID's Bureau for Global Health, Office of Population and Reproductive Health (GH/PRH) for his valuable assistance and help in the conduct of the India indepth assessment.

GH/PRH displayed the technical leadership needed to explore the dimensions of birthspacing in a programmatic context and invested the resources to better understand what is required to continually improve reproductive health services to those in need. In particular, the team would like to acknowledge Maureen Norton, whose materials were used for the technical informal discussion in La Paz, Bolivia. She is a true champion of birthspacing and meeting the needs of women and children in the developing world.

ACRONYMS

ADAR	Asociación para el Desarrollo Amazónico Rural (Association for Rural Amazonian Development) (Peru)
ADRA	Adventist Development and Relief Agency International
APROPO	Apoyo a Programas de Población (Advocacy in Population Programs) (Peru)
BCC	Behavior change communication
CA	Cooperating agency
CEDPA	Centre for Development and Population Activities
CIES	Centro de Investigación, Educación y Servicios (Center for Investigation, Education and Services) (Bolivia)
DHS	Demographic and Health Survey
FESAL 98	El Salvador National Family Health Survey 1998
FHI	Family Health International
FP	Family planning
GH/PRH	Bureau for Global Health, Office of Population and Reproductive Health (USAID)
HCP	Health Communication Partnership
IEC	Information, education, and communication
INFO	Information and Knowledge for Optimal Health Project
INPPARES	Instituto Peruano de Paternidad Responsable (Peruvian Institute for Responsible Parenthood) (Peru)
IPPF	International Planned Parenthood Federation
JHU/CCP	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs
MINSA	Ministerio de Salud (Peru)
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
PROCOSI	Programa de Coordinación en Salud Integral (Collaborative Program for Integrated Health) (Bolivia)
PROSIN	Proyecto de Salud Integral (Integrated Health Project) (Bolivia)
PVO	Private voluntary organization
RCP	Radio Communication Project (Nepal)
SIFSA	State Innovations in Family Planning Agency (India)
STARH	Sustaining Technical Achievement in Reproductive Health (Indonesia)
SUMI	Ley del Seguro Universal Materno Infantil (Law for Universal Maternal and Infant Safety) (Bolivia)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPHOLD	Uganda Program for Human and Holistic Development
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

THE ISSUE

Recently, the topic of birthspacing and the role of timing births or pregnancies in maternal and child health have received increased attention because of new research that links longer birth intervals with substantial reductions in mortality and morbidity. For example, a 2000 study using Demographic and Health Survey (DHS) data from 18 countries and assessing the outcomes of more than 430,000 pregnancies found that children born 3 years or more after a previous birth are healthier at birth and more likely to survive at all stages of infancy and childhood through age 5 (Rutstein 2002). The difference in the risk of death was significant in 17 of the 18 countries analyzed and the increased risk of death was substantial.

When compared with children born less than two years after a previous birth, children born after a three to four–year interval were found to be

- 1.5 times more likely to survive the first week of life,
- 2.2 times more likely to survive their first 28 days,
- 2.3 times more likely to survive the first year, and
- 2.4 times more likely to survive to age 5.

The same study concluded that two-year birth intervals are associated with higher child mortality risks than births occurring at 36–month intervals and represent

- a 26 percent increased risk of death for newborns,
- a 43 percent increased risk of death in infants, and
- a 51 percent increased risk of death among children under 5.

Analyses of developing countries show that demand for birthspacing is substantial, particularly among younger, lower parity women, and that much of this demand remains unsatisfied. For example, the portion of the total demand (all married women of reproductive age [MWRA]) for family planning due to an interest in spacing ranged from about 33 to 75 percent of total demand in 14 of 15 countries examined. Similarly, the portion of total unmet need among all MWRA for family planning due to spacing is also substantial, ranging from about 25 to 66 percent of total unmet need.

Among younger age cohorts, spacing is by far the main reason for any demand for family planning. For example, among married women who are 29 years or younger, the portion of the total demand for family planning for spacing reasons varied from about 66 percent to over 90 percent in 12 of 15 countries examined. In the other three countries, the demand for birthspacing represented at least 50 percent of the total demand for family planning among women who were less than 30 years old. A similar pattern emerged for married women 29 or younger for the unmet need for family planning due to birthspacing: the birthspacing portion of the total unmet need ranged from about 50 percent to over 90 percent of the total unmet need in the 15 countries.

In 2001, the United States Agency for International Development (USAID)'s cooperating agencies (CAs) began a discussion around the topic of birthspacing and began reviewing the implications of new research. Among the issues raised was the extent to which information about the health effects of birth intervals is conveyed to clients through service delivery programs in the developing world. Questions arose as well over how much of the recent research on the health impact of birth intervals is reflected in programs internationally.

TASK AND METHODS

The scope of work for this birthspacing programmatic review indicated that two broad questions should be addressed:

- How effectively are programs educating families, providers, and policymakers about birthspacing as a maternal and child health intervention?

- What program improvements are needed?

The purpose of the review included determining how well service delivery programs are or have been informing families about the health effects of birth intervals, and to describe the place of birthspacing within current service delivery efforts.

In response, the assessment team developed a multifaceted methodology for the collection of information for the assessment of birthspacing in programs. Information gathering included three general efforts focusing upon activities in-country, communications materials generally available, and examples of training materials submitted by CAs. For country-level data collection, USAID asked the PRIME, CATALYST, and Advance Africa projects as well as EngenderHealth to assist in gathering information within countries. CA staff used the standard questionnaire instrument and assessment guidelines to gather information from informants in-country and to report their findings.

Information (gathered by CA staff) from 17 countries in Africa, Asia, and Latin American was used in the assessment of birthspacing at the country level. The 17 countries in the assessment were Bangladesh, Bolivia, Egypt, El Salvador, Ethiopia, Guatemala, India, Jordan, Kenya, Nepal, Nigeria, Pakistan, Paraguay, Peru, Rwanda, Uganda, and Yemen. Additionally, members of the assessment team conducted information-gathering visits to 5 (Bolivia, India, Nigeria, Peru, and Uganda) of the 17 countries.

MAIN FINDINGS

Policy, Norms, and Standards

At the sectoral level, 13 of the 17 (76 percent) of the countries examined have policies and policy documents that acknowledge a role for birthspacing in family planning service delivery. National-level policies in 4 of the 17 countries do not mention birthspacing significantly. Typically, policies that mention birthspacing link it to improvements in the general health of mothers and children. **Most policies or standards, however, do not**

relate birth intervals to any specific health risks and there usually is no clear linkage between birthspacing or birth intervals and mortality. Birthspacing is usually dissociated from mortality-reduction objectives in health policies, service standards, program management norms, and practice guidelines.

When a birth interval is mentioned, policies and standards most often include a two-year time period in accordance with national understanding of World Health Organization (WHO) guidelines. For example, public sector policies in 7 of the 17 countries identify a two-year interval, 3 countries identify a two to three–year interval, and 7 countries do not specify an interval. In practice, however, most of the countries exhibit internal inconsistencies with regard to recommended birth intervals, usually ranging from two to three years.

Communications and Birthspacing

More than half (9 of 17) of the countries have some communications efforts that include birthspacing topics. **The content of the communications, however, often does not relate birthspacing with any specific health risk**. In Nepal, Bolivia, and Peru, for example, birthspacing messages promote the economic benefits of spacing. Although there are some exceptions (Bangladesh and Jordan), zero parity women generally are not included in efforts to educate women about postponing a first birth. In seven countries, there was no use of mass media on family planning communications at all (for spacing or limiting).

A search of the communications materials database at the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHU/CCP) indicated that of the 4,353 examples of family planning communications materials assembled from countries worldwide, only about 6 percent were coded as having any birthspacing content. When birthspacing was included in the assembled communications materials, it was rarely associated with specific health risks. For, example, 5 percent or less of the examples of birthspacing in communications materials were linked to maternal mortality, infant mortality, high-risk pregnancies, or adolescent pregnancy.

This pattern suggests that birthspacing has received weak treatment in communications efforts in the past. Some of the current, stronger examples of birthspacing communications were developed recently and often are being implemented on a pilot basis in a limited area of a country.

Training and Birthspacing

An independent review of training materials revealed a similar situation with regard to birthspacing. The review found the following gaps or missed opportunities in training materials for conveying the relationship between birthspacing and reducing health risks:

- half of the documents discussed the potential needs of young, low parity women;

- 10 percent of the documents recommended counseling techniques that can be effective for contraceptive choices for zero parity women; and

- 20 percent of the documents included the concept that some zero parity women are interested in postponing their first birth.

Birthspacing messages in these documents, for the most part, addressed the needs of adolescents, teenagers, young people, women under 18, postpartum women, and postabortion women. The birthspacing needs of postadolescent (19 or older), zero parity women were almost always overlooked.

Barriers to Birthspacing

Respondents to the questionnaires applied in the countries identified barriers that some women face when trying to exercise their birthspacing desires. Although responses varied, some barriers were common across many countries, including cultural traditions and norms; gender inequality, including intimate partner violence; lack of knowledge of contraceptive methods or source; myths, fears, and health concerns about contraceptives; lack of contraceptives; method failure; poor quality of services (including provider bias and poor counseling); problems accessing services; and poverty. Fourteen of the 17 country reports submitted by CAs cited the lack of contraceptives as a barrier to birthspacing (Egypt, Jordan, and Nigeria were the exceptions).

CONCLUSIONS

Based on all the information gathered and the independent assessments of programs, training materials, and communications efforts, it is clear that birthspacing interventions are often a weak part of family planning programs. Assumptions are common that birthspacing efforts are an integral and active element of family planning programs; however, the findings of this assessment suggest that this is not necessarily the case. **The specific health benefits of longer birth intervals are usually not a program emphasis within family planning service delivery organizations**. Furthermore, the fact that birthspacing services are not typically a part of health interventions being pursued in countries by those offices charged with reducing maternal or child mortality illustrates that **there are significant programmatic gaps between contraceptive service delivery and the contribution longer birth intervals could make to improvements in maternal and child health**. As long as these gaps exist, the potential contribution of longer birth intervals to mortality and morbidity reduction is unlikely to be fully realized.

KEY RECOMMENDATIONS

National polices should acknowledge the significant role of birthspacing in mortality reduction strategies. If the potential contribution that birthspacing can make to mortality reduction is to be realized, policies need to clearly recognize the importance of longer birth intervals to mortality reduction. Future policy discussion efforts should include an effort to have birthspacing services identified as a legitimate intervention for reducing both maternal and child mortality.

Policies and service delivery guidelines should focus birthspacing efforts on young, low parity women. Policies should also clearly acknowledge the segments of the population (young, low parity women) that can most benefit from birthspacing. Zero

parity women, particularly, need to be identified in policies and service delivery guidelines as having some preexisting demand for birthspacing and as being eligible for quality services that require the attention of service providers and program managers.

Training needs to better prepare health care workers to provide birthspacing services that respond to the needs of young, low parity women, particularly in counseling. Donors (such as USAID, the United Nations Population Fund [UNFPA], WHO, and the United Nations Children's Fund [UNICEF]) should develop standard protocols for training providers to respond to the needs of young, low parity women, including the recently married, zero parity woman. Additionally, USAID could include a specific birthspacing training component in its relevant global projects to develop model training protocols for birthspacing. Such training protocols should be oriented to service providers, supervisors of service providers, and service delivery program managers.

Communications should educate about the specific health risks associated with the timing of pregnancies. Greater effort is needed in future communications efforts to incorporate messages about the specific health risks that can be minimized through longer birth intervals. Additional counseling and client–provider interaction tools are needed for use with young, low parity women. Additional information materials on birthspacing for the zero parity, recently married woman are needed. Given the relative weakness of birthspacing in communications efforts in some countries historically, greater emphasis should be given to birthspacing messages, with clearer health content, within globally and bilaterally funded communications programs for reproductive health.

Communications are needed to address the barriers women face in exercising choice for the timing of pregnancies. Behavior change communication activities should be increased that address the barriers women face (such as lack of knowledge, fear of side effects, and provider bias) in implementing their birthspacing desires. Similarly, communication and program efforts need to develop culturally appropriate strategies for reaching men and other family members (such as mothers-in-law) about how healthy birth intervals can reduce health risks.

Specific needs of at-risk women should be addressed in service delivery programs. In countries where intimate partner violence is a substantial issue, greater emphasis is needed to ensure that women have contraceptive options that are not partner compliant–dependent. Reaching males with information about the health benefits of birthspacing is also of primary importance. With gender inequalities frequently mentioned as an issue affecting the ability of women to time pregnancies when they choose, efforts are needed to involve males in achieving improved health outcomes for women and children through birthspacing.

A commonly used sector-level indicator across countries for the status of birthspacing is needed. If birthspacing is to be taken more seriously than it currently is, it needs to be reflected in the standards of program success that donors and program managers regularly use. Therefore, age-specific birth intervals should be incorporated as a standard program indicator or for measuring progress against Strategic Objectives in both population and maternal and child health sectors. Age-specific interval information will provide important perspectives for programs to better understand which portions of the client population have the greatest need for birthspacing services. This indicator also

would allow programs to orient outreach services more precisely than is currently possible.

The right to know about the health risks associated with the timing of pregnancies should be a guiding principle for all service delivery programs. Donors and development agencies should advocate for the principle within service delivery programs of women's right to know of the correlation between birth intervals and health risks for women and children. To incorporate this principle meaningfully in many programs will require considerable support and assistance, from policy discussions, to training, to communications efforts and management priorities.

Birthspacing Programmatic Review
Summary Matrix of Key Findings from Data Collection and Analyses

Issue/Question	Finding		Information Source
Countries with birthspacing referenced in policies, procedures, and standards	*Some* (13 of 17) *None* (4 of 17)	76% 24%	Birthspacing review questionnaires/ country reports from 17 countries
Countries with stated birth interval in policies and standards	*2 years* (7 of 17) *2–3years* (3 of 17) *3+ years* *None* (3 of 17)	41% 18% 0 18%	Birthspacing review questionnaires/ country reports from 17 countries
Countries that link mortality with birth intervals at policy level	1 of 17	6%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Countries with service delivery protocols, standards, and guidelines linking birth intervals to mortality reduction		0	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Family planning communications with any birthspacing content (n = 4,353 items collected worldwide)	*Some* *None*	6% 94%	JHU/CCP communications database
Inclusion of specific health risks within communications that have birthspacing content (n = 801 items collected worldwide)	*Maternal mortality* *Infant mortality* *High-risk pregnancy* *Adolescent pregnancy*	4% 3% 5% 2%	JHU/CCP communications database
Most common issues countries report as affecting women's birthspacing choices	*Cultural* *Knowledge* *Gender Inequality* *Contracep. Supply*	82% 76% 76% 71%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Leaders' awareness of health implications of birthspacing	*Generally* *Somewhat* *None*	59% 18% 24%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Common needs identified in countries to strengthen birthspacing for health improvements	*New/spec. policy* *Service protocols* *Interval standards*	71% 53% 53%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Use of survey data used to monitor birthspacing for programs in countries	*Yes* *No* *No response*	12% 53% 35%	Birthspacing review questionnaires/ country reports from 17 countries, and country visits
Portion of training materials (10 sets) that cover health benefits derived from birth intervals	*Do* *Do not*	44% 56%	Training materials review by C. Davis, Johns Hopkins University (JHU)
Training material (10 sets) cover birthspacing counseling for zero parity women	*Do* *Do not*	0 100%	Training materials review by C. Davis, JHU

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